wards, as well as in checking hemorrhage, must commend the more general practice of it in preference to trusting chiefly to manipulation of the internal uterine surface; while no one can forget to take into account the greater risk by the latter method of increasing the hemorrhage, before it can be satisfactorily carried out, or other remedial means can be put in operation to cause the uterus to contract sufficiently. And in this readiness of application lies the true value of external compression when early made, as a preventive and effective power in post-partum hemorrhage, and of irregular contraction of the uterus after placental delivery in multiparous women."

62. *Retro-Uterine Hæmatocele.*—Mr. W. F. WADE, Senior Physician to the Queen's Hospital, Birmingham, calls attention (*Lancet*, Sept. 10, 1864) to a hitherto unrecognized method in which nature effects a cure in these cases. "It must be premised," he says, "that by retro-uterine hæmatocele I mean an effusion of blood into the cavity of the peritoneum, to the lowest point of which it falls by gravitation. This point is, in the vast majority of cases, the pouch formed between the rectum and uterus, known as 'Douglas's space.' It is not doubtful that blood may be, in some cases, effused into the sub-peritoneal cellular tissue. It is, however, very doubtful whether in that case it gives rise to those symptoms of peritonitis which form so prominent a clinical feature of the intra-peritoneal variety. A case published by Dr. Lever, and my own experience of the consequences of aneurism rupturing behind the peritoneum, led me to believe that an accident of this kind does not lead to peritonitis. A careful study of published cases of retro-uterine hæmatocele affords most convincing evidence that no case has yet occurred in which symptoms of peritonitis during life had been found after death to depend upon hemorrhage purely extra-peritoneal. That is to say, no published dissection of retro-uterine hæmatocele proves the existence of an extra-peritoneal variety. The spontaneous cure of this disease has hitherto been supposed to be confined to four methods, or to combinations of these methods—

a. Absorption of the blood.
b. Its escape by rupture of the rectum.
c. " " " bladder.
d. " " " vagina.

"Without disputing the possibility of the sac[1] emptying itself into the vagina by perforation, it is a singular fact that in no instance (within my knowledge) has the opening been seen, though the speculum has been frequently employed in such cases. Further, the assumption which has seemed to render this theory independent of actual observation is an untenable one. The argument by which this theory is sustained is evidently (though not categorically stated) as follows: Escape of altered blood per anum indicates necessarily perforation of the rectum, since there is no natural channel by which the cyst contents could enter the rectum. So escape of altered blood per vulvas indicates necessarily perforation of the vagina, since there is no natural channel by which the cyst contents could enter the vagina. The fallacy lies in the assumption that there is no natural channel by which the cyst contents can enter the vagina, and so escape per vulvas.

"I have come to the conclusion that the contents of the cyst may get into the vagina by an already existing route—viz., through the Fallopian tubes and uterus; and observation has led me also to conclude that this is the method which nature employs in a large number of cases either independent of, or in conjunction with, some of the other methods above enumerated. In the first place, ovarian tumours are known to have emptied themselves through the uterus. When labour-like pains precede for some time, and at last culminate in, a sudden gush of fluid per vaginam, followed by a subsidence of the extrusive pains, we may justly infer that the fluid has found its way into the uterus, and

[1] By "the sac" is meant that portion of the peritoneum in the cavity of which the blood is retained, and which is separated by inflammatory adhesions from the general peritoneal cavity.

been thence expelled. In 1850, Dr. Hill, at that time Demonstrator of Anatomy in the University of Dublin, informed me that he had had an opportunity of introducing the speculum during the continuance of such a discharge, and had seen the ovarian fluid escaping from the os uteri. This discharge was attended with the labour-like symptoms referred to above. The tumour was cured.

"Such an escape might take place in one of four ways:—

"*a.* By direct application and adhesion of the fimbriated extremity to the wall of the ovarian cyst, and the subsequent bursting of the latter at that point.

"*b.* By a similar adhesion of the ovarian cyst to the fundus uteri, and subsequent rupture at that point.

"*c.* By rupture of the sac, and extravasation of its fluid into the peritoneal cavity, and by subsequent perforation of the fundus uteri.

"*d.* By similar rupture and extravasation into the peritoneum. The fluid subsequently percolating through the Fallopian tubes into the uterus.

"The last supposition is, to my mind, the most probable one; and the fluid in such a case would, after the sac had ruptured, lie in exactly the same relation to the Fallopian tubes that the extravasated blood does in retro-uterine hæmatoceles of any size.

"The possible escape of ascitic fluid through the Fallopian tubes is not mentioned by any medical author within my knowledge. Yet I remember seeing a case, when a student at the Meath Hospital, where I had no doubt that an ascites was so cured. It is proper, however, to add that Dr. Stokes, under whom the patient was, declined to give any opinion as to the channel by which the fluid had escaped. A woman, aged about fifty, had been long ill of heart disease, which at last produced general anasarca and copious ascites. One night she was seized with labour-like pains of great severity. These, after lasting for some hours, were attended and relieved by a large gush of clear fluid from the vagina. For several days this discharge persisted, sometimes in gushes preceded by uterine pains, sometimes continuously trickling. There was progressive diminution, and finally a total disappearance of the ascites. Having left the Meath, she subsequently entered Sir Patrick Dun's Hospital a few weeks later, and there died of a return of the general dropsy. At my request the uterine organs were particularly examined. There was no ovarian disease, and no marks of any former preternatural opening into the uterus. The tubes were normal. There could be no doubt that in this case the fluid came from the uterus. By what process? There may have been possibly a hydrometra producing a derivation from the peritoneum. If so, why did it cure the ascites only without affecting the dropsy elsewhere? It seems to me a more simple and probable explanation that the ascitic fluid trickled directly into the womb through the Fallopian tubes. The wonder really is, not that this should happen once, but that it does not more frequently occur.

"To return now to uterine hæmatoceles. Dissection has proved that in some of these cases the fimbriated extremities of the tubes lie gaping in the sac; that the tubes themselves, through a greater or less portion of their extent, are filled with a fluid identical with that remaining in the cyst. This has been supposed to prove that in such cases the blood has been originally poured out by the tubes themselves into the peritoneum. But the facts are quite as much in favour of my supposition that the blood has entered them from the peritoneum. There are, however, other facts and arguments which do not cut both ways.

"Certain cases have been recorded in which blood, more or less altered in the way that the intra-peritoneal blood is known to alter, has entered the vagina, not through a fissure in its wall, but through the uterus. It has been occasionally seen to do so by means of the speculum. Or the uterine sound, on its withdrawal, has been found to be smeared with fluid of this kind. Or, again, the symptoms preceding and attending the discharge have been of such a character as I hold to be sufficient circumstantial evidence of a uterine flow. In such cases it has been too hastily taken for granted that these discharges are necessarily menstrual. And since they are commonly attended with diminution of the tumour, menstration has been most incorrectly inferred to be, if not an actual method of cure, at all events a favourable circumstance. It is possible that menstruation may promote the absorption of the fluid, but in my experience it is much more likely to produce an increase in the effusion, and I always anticipate the first menstruation during convalescence with a considerable amount of anxiety and fear of relapse. But it cannot be conceded that such uterine discharges always are menstrual. In the first place they do not always occur at a menstrual epoch. Secondly, they resemble in odour, consistence, and colour the fluids which are discharged through a fissure of the rectum, or which are found in the cyst after death. Lastly, a real and natural menstrual discharge at a proper epoch may precede or follow them. The patient will always observe that the one discharge is like that of ordinary menstruation, the other not. These discharges will reduce the size of the tumour in the very cases where menstruation of an ordinary character has not diminished or has actually increased them. As illustrations of the correctness of these views the following references may be interesting:—

"1. In an hospital case of my own, diminution of the tumour attended a discharge of fetid and discoloured sanious fluid, both while she was in the hospital and afterwards. This discharge was not continuous, and was accompanied by cramp-like pains in the region of the uterus; no vaginal fissure was ever seen. A discharge of ordinary menstrual appearance was associated with decided increase in the volume of the tumour.

"2. In a patient of M. Tardieu (Voisin's fourth case) great diminution of the tumour coincided with a sanguineous discharge, ascertained by the speculum to be from the uterus, and occurring at a non-menstrual epoch, attended with sharp expulsive pains.

"3. In another patient of M. Tardieu at Lariboisière Hospital (Voisin, No. 5) no decrease of the tumour was noted at a menstrual period; whereas there was diminution from the size of a fœtal head at eight months to that of a middle-sized apple after the discharge per vaginam, with severe uterine pains, on three separate days between twelve and twenty-one days after a menstrual epoch. After remaining stationary for some time, the tumour again decreased after other discharges at a non-menstrual period.

"4. In Voisin's fifteenth case diminution of the tumour coincided with a menstrual epoch and discharge, but this latter was partly blackish and partly red. There is no reason at all why discharge of altered blood in the way I suggest should not take place at the same time as a menstrual flux.

"5. In another case, under my care at the Queen's Hospital, the altered blood was seen, by means of the speculum, to ooze from the os uteri, and it oozed faster when pressure was made upon the abdominal tumour.

"6. In another case, lately under my care, a discharge of altered blood was also seen to ooze from the os uteri. The patient observed that is was totally unlike any menstrual flow she had ever had. In this case and in others the discharge has been more copious when the patient has been up and about. I therefore now allow these patients to rise as soon as the absence of peritonitic symptoms enables them to do so with comfort, instead of keeping them in bed as formerly.

"7. Voisin's thirty-third case is headed 'Retro-Uterine Hæmatocele, apparently due to excesses of all kinds, in a Woman subject to Menorrhagia; Spontaneous Evacuation of the Fluid by the Vagina; Cure.' The case is too long to quote entire. It is fortunately easily accessible to those who are interested in the subject. The diagnosis was made by M. Nélaton, and admits of no doubt. I extract the following: 'On the 7th of February,' after several days of severe pain in the lower part of the body, 'there came from the vagina a very abundant sanguinolent flux, consisting of a brownish liquid, compared by the patient to coffee with milk or to chocolate. 8th. Discharge presents same character; no clot. 9th to 12th. The discharge continues very abundant, but the blood is of a clearer colour. 12th and 13th. Passes some brownish clots, the size of which she cannot tell. The blood has again become darker. 14th. Since the discharge commenced the pains have sensibly diminished, so much so indeed that the patient feels pretty well. 15th. The bloody discharge stops to-day. The pains are less; but she feels very weak, perspires continually, and is markedly thinner. The skin has become more pale; the gums and conjunctivæ a little blanched. The tumour has much diminished in size; palpation shows that the contents are now partly solid. M. Nélaton thinks that there has been perforation of the vagina, and that through this the liquid part of the tumour has been evacuated, and that there has been at the same time a discharge of blood from the uterus; but he does not think that this discharge has been menstrual, for she menstruated on the 19th of last month, and this discharge commenced on the 7th. But the patient tells me (M. Robin-Massé, the reporter) that for some time the menstrual epoch has continually advanced, and returns about every three weeks.' It is to be remembered that in this case the disease was developed in conjunction with menorrhagia. And at the next return of the menses there was a return of pain, which not only preceded the discharge, but also accompanied it, ceasing when the discharge ceased; whilst in the foregoing account it will be noticed that the pains began to be relieved as soon as the discharge commenced. The only question is, whether the flow in this case was altogether uterine, or partly through a perforation of the vagina. This can now never be decided, as the speculum was not used. It is not like the way in which the fluid is discharged by a perforation of the rectum.

"8. In Voisin's thirty-sixth case there was rapid diminution of the tumour after a discharge, firstly, of serous, and subsequently of sanguinolent fluid. After the discharge had become sanguinolent, M. Voisin examined the patient with the speculum, and found no orifice in the supero-posterior cul-de-sac. The fluid, he says, came from the uterus. The discharge occurred at a non-menstrual period. This case is an illustration of what I have myself seen in two cases—viz., the discharge of a serous fluid, probably, I think, from the cavity of the cyst. But in my cases it occurred when the patients were getting well, and the functions of the peritoneum approached restitution.

"9. In Voisin's twenty-seventh case: 'Sanguineous discharge from vagina; lumbo-sacral pains, intermittent and at times expulsive; death. Fallopian tubes distended with blood, adherent to ovaries, but *communicating* with the cavity of the hæmatocele.'

"*Recapitulation.*—In cases of hæmatocele, we observe a discharge of altered blood, similar to that which flows from a perforation of the rectum, preceded by uterine pains, and seen to flow from the uterus; followed by rapid diminution of the tumour, and increased solidity of it, occurring at a non-menstrual period, the colour and odour of it being dissimilar to those of the menstrual fluid. I submit that we may infer that this fluid comes directly from the cyst into the uterus, into which it probably finds its way through the Fallopian tubes."

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63. *Mortality in the Vienna Lying-in Hospital.*—Prof. Spaeth of Vienna has given a sketch of the Lying-in Hospital at Vienna from 1784 to 1863. The hospital was established by Joseph II. in 1784. From 1784 to 1822 it was under the direction of Simon Zeller and J. L. Boër. The number of births during that period were 71,395, and the number of deaths 897; the mortality being about 1.25 per. cent. The epidemics during this period of thirty-seven years were not severe. From 1822 to 1833—the time when the second clinical lying-in department was established—32,336 women were delivered; and of these 1714 died, being a mortality of 5.30 per cent. During these eleven years epidemics were almost constantly present. From 1833 to 1839, Klein and Bartsch directed the hospital; and during this period there were in the first clinique, 12,253 births and 902 deaths, and in the second clinique 9354 births and 620 deaths; consequently, the mortality of women was 7.36 and 6.62 per cent. Puerperal diseases were almost constantly present; but were most fatal in the year 1836–37. During the next period, 1839 to 1847, the management of the two cliniques was altered, the physicians having exclusive charge of the first clinique, and the second clinique being chiefly under the management of midwives. The effect of this change was well marked. The mortality in the second clinique diminished; of 21,155 women confined, 810, or 3.82 per cent., died; whilst under the fearful epidemic of 1842–43, the mortality at the first clinique increased to a terrible height, 2482, or 10.14 per cent., dying, out of 24,455 confined. The greatest mortality occurred in December, 1842, reaching, in fact, to 31.3 per cent. In 1847, Dr. Semmelweiss called attention to the origin of puerperal diseases, through infection from decomposed animal matters, and